Maternal Infant Health Program (MIHP) Benefits Administered by the Medicaid Health Plans
Frequently Asked Questions

#	Category	Question	Answer
B1	Benefits	Will MIHP providers continue to provide transportation to Nurse Family Partnership (NFP) participants?	The Medicaid Health Plans are responsible for providing transportation for Medicaid Health Plan covered services for Medicaid Health Plan enrolled MIHP and NFP participants, including transportation for pregnancy-related appointments. MIHP providers may continue to bill Fee-for-Service (FFS) for transportation services provided to NFP participants for FFS Medicaid beneficiaries.
B2	Benefits	Transportation services seemed to be more accessible to beneficiaries when provided by MIHP providers rather than through the Medicaid Health Plans. Will this be an option?	Beginning January 1, 2017, MIHP providers must follow the Medicaid Health Plan's internal processes to coordinate transportation services for Medicaid Health Plan enrolled beneficiaries. Codes and associated fees located on the MIHP database will no longer be applicable for claims for transportation services provided by in-network or out-of-network MIHP providers to Medicaid Health Plan enrollees. MIHP providers will no longer be eligible for the administrative fees associated with transportation services provided to Medicaid Health Plan enrollees. There will be no impact to MIHP transportation services provided to FFS beneficiaries. MIHP providers are encouraged to discuss with the Medicaid Health Plans, or their transportation vendor, the options for enrollment as a transportation contractor. Individual MIHP providers (not the agency) may also provide transportation and use the health plan gas mileage reimbursement process in place for volunteer or family/friend drivers (complete the health plan mileage reimbursement forms) to receive payment for mileage. MIHP providers should discuss these operational details with the Medicaid Health Plans.
B3	Benefits	Will the Medicaid Health Plans cover bus tickets for transportation?	Medicaid Health Plans have the responsibility for providing transportation (including bus tokens) for MIHP services. See B2.

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B4	Benefits	The current list of MIHP covered services is very limited. Are the services on the MIHP fee schedule the only services payable to the providers?	Yes, the MIHP fee schedule contains all MIHP reimbursable codes.
B5	Benefits	Some MIHPs offer childbirth education classes. Should transportation be a covered benefit for these classes if the MIHP is the agency providing the class?	Yes, transportation to childbirth education classes is a covered benefit, regardless of who provides the childbirth education service.
B6	Benefits	The Medicaid Provider Manual states that nine visits are covered per pregnancy. Please confirm that the visit maximum relates to preventive counseling codes. Are there other maximum benefit limits for other services on the MIHP fee schedule? For example, number of childbirth education classes. Is there a limitation on the number of classes per pregnancy? Are multiple education classes completed on same day reimbursable or do they have to be performed on different dates? Is the fee schedule for the education classes reimbursed per class of completion of the education program?	The program covers one maternal assessment visit with nine professional (99402) visits. It also covers one infant assessment visit with nine professional visits (99402), with an additional nine professional visits with a physician's order (99402), and 18 additional visits with a physician's order and the diagnosis of drug-exposed infant (96154). One professional visit is payable for a single date of service. Childbirth education (S9442) may be billed once per beneficiary per pregnancy, parenting education (S9444) may be billed once per infant (or in the case of multiples, once per family). Medicaid policy allows for two visits provided for comprehensive lactation support (S9443) within the 60 day postpartum period. The Medicaid Health Plans will not impose a prior authorization requirement on the aforementioned services when the services are provided within the context and quantity limits established by Medicaid Policy.

#	Category	Question	Answer
B7	Benefits	Please confirm how transportation services will be covered. Will these be coordinated through the Medicaid Health Plan providers? MIHP covers transportation to behavioral health, substance abuse and Women, Infants, and Children (WIC). How will these be handled as these services may not be covered by the Medicaid Health Plan? The Medicaid Provider Manual says that MIHPs can provide transportation for substance use disorder and mental health services, how will this work if services are carved out? Is this provided by the PIHP?	The Medicaid Health Plan will provide transportation to individuals enrolled in the MIHP including transportation to WIC, behavioral health services (including substance use disorder), and oral health services. The MIHP provider should work with the health plans to coordinate pregnancy-related transportation services.
B8	Benefits	How is coordination of benefits (COB) handled? Since this is a Medicaid only benefit and not covered by commercial insurance, are MIHP providers subject to COB and Third Party Liability (TPL) rules?	Because MIHP services are a Medicaid-only benefit, MIHP providers are not subject to COB and TPL rules. MIHP providers do not need to bill a commercial insurer and receive a denial prior to billing the Medicaid Health Plan for services.
B9	Benefits	Does the transportation benefit include trips to a methadone clinic?	Yes, the Medicaid Health Plan will provide transportation for individuals enrolled in the MIHP including transportation to WIC, behavioral health services, substance use disorder, and oral health services. The MIHP provider should work with the health plans to coordinate pregnancy-related transportation services.

Maternal Infant Health Program (MIHP) Benefits Administered by the Medicaid Health Plans
Frequently Asked Questions

#	Category	Question	Answer
B10	Benefits	Can a Licensed Master Social Worker (LMSW) provide counseling services within the MIHP? Can these counseling services be provided under the same contract between the Medicaid Health Plan and the MIHP?	No, behavioral health counseling services are not an MIHP covered service. Outside of the MIHP program and contract, LMSWs are eligible to enroll as Medicaid providers for behavioral health services and could engage in discussions to become a contracted provider with a Medicaid Health Plan. Providers must be compliant with all federal rules against self-referral.
B11	Benefits	Will Medicaid Health Plans cover transportation to MIHP office visits, including clinic only programs?	Yes.
B12	Benefits	How about Early Head Start and Early On? Will Medicaid Health Plans pay for these services along with MIHP services?	No, the Medicaid Health Plans are not required to pay for Head Start or Early On. However, Medicaid Health Plans may provide additional Medicaid non-covered services at their discretion.
B13	Benefits	I have concerns about Medicaid Health Plans offering to pay for services to older children. The program is designed to serve infants.	Screening tools and educational materials utilized by the MIHP are designed for use with infants. The initial assessment visit for a child older than 12 months of age or a professional visit or other MIHP service beyond 18 months of age is subject to Medicaid Health Plan prior authorization requirements. MIHP providers must contact the Medicaid Health Plan before providing services. Medicaid Health Plans will receive guidance from MDHHS in order to evaluate medical documentation and make a coverage determination. The MIHP provider must maintain the health plan authorization in the MIHP record.

#	Category	Question	Answer
B14	Benefits	MIHPs can provide transportation for FFS beneficiaries. Will MIHPs continue to be able to provide transportation for the first 30 days of Medicaid Health Plan enrollment?	There are no special restrictions during the first 30 days of Medicaid Health Plan enrollment; transportation should be arranged through the Medicaid Health Plan.
B15	Benefits	For transportation through Medicaid Health Plans, is there a three day wait time?	Each Medicaid Health Plan has procedures and timeframes for requesting transportation. However, all Medicaid Health Plans are required to have a process to request emergency transportation which would include same-day services. MIHP providers should discuss those details with the Medicaid Health Plans.
BA1	Benefit Administration	Each MIHP provider will have to learn processes such as billing and appeals, and those related to prior authorization requirements for each Medicaid Health Plan that they have an established contract with. This will increase the workload tremendously for MIHP providers.	Medicaid enrolled providers who bill for services rendered to Medicaid Health Plan enrollees are currently expected to be knowledgeable of business operations with the applicable Medicaid Health Plans.
BA2	Benefit Administration	Will there be a requirement of a physician's order prior to providing MIHP services?	It is not a requirement to have a physician's order to initiate MIHP services. Initiation of MIHP services may come from various sources such as from a self-referral.

Maternal Infant Health Program (MIHP) Benefits Administered by the Medicaid Health Plans
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#	Category	Question	Answer
BA3	Benefit Administration	Our clients switch Medicaid Health Plans frequently. The required contracts and variables in the operations of Medicaid Health Plans could be a barrier to the client receiving services in a timely manner as well as complicate billing.	The department will work with the Medicaid Health Plans and MIHP providers to minimize any disruption. Communication between all parties is encouraged and has been included in Maternal Child Health (MCH) workgroup meetings.
BA4	Benefit Administration	Will the Medicaid Health Plans be responsible for ensuring that the correct forms are used? If so, how?	MDHHS will continue to provide the MIHP providers with the appropriate MIHP forms. All MIHP forms may be accessed on the MIHP website at www.michigan.gov/mihp >> Current MIHP Providers >> Required Maternal & Infant Forms.
BA5	Benefit Administration	Is there a central database that houses all MIHP forms?	Yes. See BA4.
BA6	Benefit Administration	Will Medicaid Health Plans be allowed to administer the Maternal and/or Infant Risk Identifiers?	No. The Maternal and Infant Risk Identifiers may only be administered by the certified MIHP provider.
BA7	Benefit Administration	How will the MIHPs be able to handle the volume of referrals from the plans if the plans choose to contract with a minimum number of MIHPs?	The requirement to maintain provider network adequacy is included in the Medicaid Health Plan-MDHHS contractual agreement. MDHHS will monitor and ensure that Medicaid Health Plans have an adequate MIHP provider network, including specialty providers, on an ongoing basis. MDHHS will provide the Medicaid Health Plans with guidance as to what constitutes an adequate network.

#	Category	Question	Answer
BA8	Benefit Administration	A few of our clients have both commercial insurance and Medicaid. The commercial insurance will not pay for MIHP services but we are still expected to bill the primary and receive a denial before we submit claims to Medicaid. Will this process change?	It is the expectation that individuals who have a commercial Health Maintenance Organization (HMO) or Preferred Provider Organization (PPO) insurance as primary will have FFS Medicaid as secondary, not a Medicaid Health Plan. Because MIHP services are a Medicaid only benefit, MIHP providers are not subject to COB and TPL rules. MIHP providers do not need to bill a commercial insurer and receive a denial prior to billing the Medicaid Health Plan for services.
BA9	Benefit Administration	Current Procedure Terminology (CPT) code 99402 is a counseling code payable by BCBS. If a beneficiary has dual coverage and the claim is submitted to the primary insurance it will inappropriately pay. How does MDHHS recommend we bill for such services for dually enrolled beneficiaries?	MIHP services are a Medicaid only benefit therefore the MIHP provider should only bill the Medicaid Health Plan for MIHP services, including CPT 99402. The department has not changed CPT coding as a result of Bulletin MSA 16-33. Providers are expected to follow existing programmatic coding practices. See BA8.
BA10	Benefit Administration	Historically the Medicaid Health Plans have been slow to respond to inquiries. I feel strongly that their slow response will contribute to delays in our ability to provide timely services and align with policy requirements.	One of the purposes of this transition is to facilitate communication and coordination of services. MDHHS will monitor access to care and any related complaints and follow up with the Medicaid Health Plan if necessary.
BA11	Benefit Administration	Will the Medicaid Health Plans honor standing orders (e.g. dietitian)?	It is the expectation that the Medicaid Health Plans will honor standing orders.

#	Category	Question	Answer
BA12	Benefit Administration	We are concerned that with the change in administration by the Medicaid Health Plans that there will be a shift from the population-based model to a model that screens by "risks" for program eligibility.	The model of the program is not changing. The MIHP program will remain a population-based model.
BA13	Benefit Administration	Who will "handle" MIHP provider complaints?	Beneficiary and provider concerns should be directed to the Medicaid Health Plan. MIHP providers will continue to be able to submit questions and concerns to the MDHHS MIHP consultant who will, in turn, work with the MDHHS Medicaid Health Plan Contract Manager.
BA14	Benefit Administration	The proposed policy requires Medicaid Health Plans allow members to change their MIHP provider. Please confirm that if the beneficiary changes MIHP providers during the treatment, the Medicaid Health Plan will be required to cover more than one Maternal or Infant Risk Identifier per pregnancy or for the newborn?	There is a limit of one Maternal Risk Identifier for each pregnancy that a beneficiary experiences and one Infant Risk Identifier for each infant. MIHP providers, following HIPAA regulations, are encouraged to communicate with the transferring MIHP provider for access to the Risk Identifier.

#	Category	Question	Answer
BA15	Benefit Administration	The Medicaid Provider Manual says the MIHP provider enters results of the Risk Identifier into the MIHP database. Will Medicaid Health Plan case managers have access to this Database? Does the MIHP provider have to share the results of the Risk Identifier with the Medicaid Health Plan too? Is there other information entered into the system by the MIHP provider?	MIHP providers are encouraged to share the results of the Risk Identifier with the Medicaid Health Plan. The Medicaid Health Plan may, as a payer, request information to be shared. MDHHS is actively reviewing the possibility for the Medicaid Health Plans to access elements of electronic data such as the MIHP Risk Identifiers, Plans of Care, and Discharge Summaries.
BA16	Benefit Administration	What percentage of Medicaid Health Plan members receive MIHP services? Can this be broken out by percentage of pregnant women vs. percentage of infants? How many Medicaid beneficiaries participating in MIHP services complete the plan of care through discharge?	There were approximately 17,500 infants and 18,000 women who received at least one MIHP service during the time period of October, 2014 through September, 2015. Historically an infant has received an average of five professional visits. Drug exposed infants have received on average fewer than seven visits. Pregnant women received on average less than five professional visits.
BA17	Benefit Administration	Will MIHP Providers need to be added to the Provider Directories and 4275 provider file? Are there specific codes we should use to identify specialty in 4275 provider file?	Yes, all Medicaid Health Plan network providers, including MIHP providers, should be in the health plan provider directory. All Medicaid Health Plan network providers should be included in the 4275 provider file that the Medicaid Health Plans provide to MDHHS and their Enrollment Broker for enrollment purposes. Research into the 4275 layout and specialty codes indicates 0001 could be used to report MIHP providers in the file.

#	Category	Question	Answer
BA18	Benefit Administration	Proposed Policy 1611-MIHP states that if an enrollee is receiving services from a non-contracted MIHP provider at the time of enrollment with the Medicaid Health Plan, the Medicaid Health Plan must pay, at a minimum, Medicaid FFS until the case closure. For situations where mom is getting services from a non-contracted MIHP and infant qualifies for MIHP services after birth, would this requirement apply to the baby or is the Medicaid Health Plan able to transition baby to contracted MIHP providers?	Medicaid Health Plans must support the enrollee in their choice of MIHP provider and support current service relationships between the MIHP provider and enrollee. This includes extending services to the infant with the same provider who rendered maternal services. Relationships established during previous pregnancies with MIHP providers not in the Medicaid Health Plan network are not required to be covered. Any questions related to providing out-of-network services will need to be discussed directly with the individual Medicaid Health Plan prior to providing services.
BA19	Benefit Administration	Will the Medicaid Health Plans change the required staff credentials for the licensed social workers to those with an LMSW only?	No. MIHP staff credentials will remain consistent with those outlined in the MIHP Chapter of the Medicaid Provider Manual.
BA20	Benefits Administration	At times, when requested by the parents of an infant beneficiary, two separate MIHPs split the baby's visits. This has occurred when parents are estranged but both feel they would benefit, and their child would benefit, from services. It has required coordination but has worked–will this be allowed?	Policy does not prohibit this practice. Coordination of maternal and infant services is encouraged when more than one MIHP provider is involved in the family's care.

#	Category	Question	Answer
C1	Contracts and Agreements	MIHP providers may be responsible for negotiating contracts with up to eight different Medicaid Health Plans. This places a burden on smaller agencies with a limited number of staff.	It is correct that an MIHP provider may contract with more than one Medicaid Health Plan. This could prove to be advantageous for the MIHP provider by expanding the potential service area. The delay of implementation to January 1, 2017 will allow additional time for negotiating multiple contracts.
C2	Contracts and Agreements	Will MDHHS provide a contract agreement or template that could be used between a Medicaid Health Plan and an MIHP provider? Is it the intent that the State Agreement template be used for this purpose?	No. Most likely, Medicaid Health Plans will use their existing provider agreements with the MIHP providers in addition to the Care Coordination Agreement (CCA).
C3	Contracts and Agreements	Does the MIHP CCA satisfy the requirement for a contractual agreement?	No, the CCA does not satisfy the contract requirement.
C4	Contracts and Agreements	Will there be special contractual provisions to allow for the continuation of specialized MIHP services such as those for the blind or hearing impaired? Will the same apply for those specializing in various languages?	MDHHS recognizes the importance of providing such specialized services to Medicaid Health Plan enrollees and will encourage the plans to establish relationships with these specialized providers. Medicaid Health Plans have been informed how to access the MIHP provider directory which includes information related to specialty providers.
C5	Contracts and Agreements	The proposed policy discusses that MIHP providers may contract with Medicaid Health Plans in their service area. What or who defines a service area?	As with all Medicaid enrolled providers, MIHP providers are able to define the service area that best accommodates their professional operations. Medicaid Health Plans operate in their approved state-defined prosperity regions.

#	Category	Question	Answer
C6	Contracts and Agreements	Will there be a separate contract requirement for MIHP providers that service both MI Health Link beneficiaries and Medicaid Health Plan enrollees?	Yes. These are different programs that could be administered by different health plans, requiring a separate contract.
C7	Contracts and Agreements	Will the MIHPs be required to have a contract with every Medicaid Health Plan in the respective county?	No, MIHP providers are not required to have a contract with every Medicaid Health Plan in the respective county. A contract is likely required, however, for an MIHP provider to receive referrals from the Medicaid Health Plan and to be paid for those services provided to Medicaid Health Plan enrollees.
C8	Contracts and Agreements	Will the MIHP provider be allowed to turn away an eligible beneficiary if there is no established contract with that beneficiary's Medicaid Health Plan?	The MIHP provider is encouraged to work with the Medicaid Health Plan to obtain a referral to an in-network MIHP provider or discuss the possibility of out-of-network arrangements.
C9	Contracts and Agreements	Providers in areas where there is only one MIHP provider will have much more negotiating power with the plans compared to those who compete with other MIHPs in the same county.	It is acknowledged that this is a possibility. Negotiation of contracts, including rates, with the Medicaid Health Plans, is a business process that allows for opportunities that may also benefit the MIHP provider.
C10	Contracts and Agreements	If I try to negotiate for higher rates than the other MIHPs in my area, I risk having a health plan refuse to contract with me.	It is acknowledged that this is a possibility. Negotiation of contracts with the Medicaid Health Plans, including rates, is a business process that allows for opportunities that may benefit both the plan and the MIHP provider.
C11	Contracts and Agreements	Is there specific language that will need to be included in the contract to meet MIHP requirements?	Contract language should support the delivery of MIHP services consistent with policy, fidelity of the model, and applicable state statute.

#	Category	Question	Answer
C12	Contracts and Agreements	Will the Medicaid Health Plans be able to deny contracts with MIHPs?	Yes.
C13	Contracts and Agreements	Will each MIHP provider need to be credentialed with each Medicaid Health Plan?	Yes, in addition to the MDHHS certification process, MIHP providers must be credentialed and contracted with a plan, unless indicated otherwise by the Medicaid Health Plan, in order to receive payment for services provided to plan enrollees.
C14	Contracts and Agreements	If your home care agency, Local Health Department (LHD), or Federally Qualified Health Center (FQHC) already has a contract with a Medicaid Health Plan, is an additional contract required? Is additional liability insurance required?	Agencies must contact the individual Medicaid Health Plan regarding specific contractual agreements for the provision of MIHP services, including liability insurance requirements.
C15	Contracts and Agreements	Can the Medicaid Health Plans establish contractual performance metric expectations for each MIHP related to HEDIS pregnancy measures, FPC, and postpartum care, and well child exams? Can the plans also establish performance metric expectations for MIHP service response timeliness?	Yes, the Medicaid Health Plans can establish performance metrics for their contracted MIHP providers. MDHHS and the Medicaid Health Plans will attempt to align any additional data collection and performance measurement requirements so that these can be operationalized in the most efficient manner possible.
C16	Contracts and Agreements	Are those MIHP providers that are certified by MDHHS the only agencies allowed to provide MIHP services or would certification from the U.S. Department of Health and	All MIHP providers must be certified by MDHHS.

#	Category	Question	Answer
		Human Services (HHS) be sufficient?	
C17	Contracts and Agreements	Please confirm the impact to the existing CCA once this transition is complete. Should MIHP and Medicaid Health Plans terminate these CCAs after implementation? Will CCAs be required for non-contracted MIHPs in situations where MIHP provides services for continuity of care prior to enrollment with Medicaid Health Plan?	The MIHP/Medicaid Health Plan CCA should not be terminated. CCAs will continue to be a program requirement.
C18	Contracts and Agreements	Please confirm if Medicaid Health Plans should use existing provider agreements for the MIHP providers. Will MDHHS require specific language be added to Medicaid Health Plan/MIHP provider agreement around care coordination? As a separate document? If so, when will this be available? Plans will need requirements as soon as possible. Changes to existing provider agreements may require Department of Insurance and Financial Services (DIFS) approval and delay contracting efforts.	Most likely, plans will use existing provider agreements with the MIHP providers in addition to the CCA. MIHP providers should work with each Medicaid Health Plan in their service area to negotiate contracts. As stated above, MIHP/Medicaid Health Plan CCA should not be terminated and will be required even in out-of-network situations. The delay of implementation to January 1, 2017 will allow additional time for negotiating multiple contracts.

#	Category	Question	Answer
C19	Contracts and Agreements	Does only the MIHP provider entity enroll in the Community Health Automated Medicaid Processing System (CHAMPS) as a provider? Do the practitioners (i.e., SW, RN, dietitian) have to enroll too?	As it pertains to MIHP services, only the MIHP provider enrolls in CHAMPS, not individual staff within the agency.
C20	Contracts and Agreements	Will there be consistency with the various components of liability insurance by the Medicaid Health Plans?	Each Medicaid Health Plan may determine their specific requirements related to liability insurance for in-network providers.
C21	Contracts and Agreements	Do individual staff of the MIHP agency need liability insurance?	The MIHP provider may be required to maintain liability insurance. Individual MIHP staff are not required to have liability insurance.
C22	Contracts and Agreements	What is involved in the credentialing process? May we start the credentialing process now?	The credentialing process will vary from plan to plan. At a minimum, MIHP providers will need MDHHS certification. Medicaid Health Plans notify MDHHS when they are ready to begin the contracting and credentialing process. An indicator will be added to the Medicaid Health Plan Contact List and this list will be reissued on a regular basis.
C23	Contracts and Agreements	If an MIHP provider does not have a contract with a Medicaid Health Plan but they provide other services such as immunizations and family planning services to health plan enrollees, will they be able to provide MIHP services without a contract and be paid FFS rates.	Providers should not assume they do not need a contract. It is recommended that agencies check with each health plan in their service area for provider contracting requirements.

#	Category	Question	Answer
C24	Contracts and Agreements	Is it beneficial for MIHPs in the same county or area to collaborate in contract discussions (rate negotiation) with Medicaid Health Plans?	Medicaid Health Plans will be utilizing provider agreements already approved by DIFS. Rates are part of the contractual negotiation between the individual MIHP provider and the Medicaid Health Plan.
C25	Contracts and Agreements	Are "in-network" and "contracted" provider terms being used interchangeably?	Yes.
C26	Contracts and Agreements	Do Medicaid Health Plans anticipate not contracting with all certified MIHPs for any reason, assuming the MIHPs meet requirements (other than volume)? For example, will lower volume MIHPs automatically fail? Any denial of contracts to Medicaid eligible MIHPs sounds unlawful and granting contracts based on volume can be viewed as unlawful in relation to small businesses. Also, granting contracts to certain MIHPs seem to possibly cross into "monopoly."	Medicaid Health Plans will determine which MIHP providers they will contract with based on several factors including: service area, quality, responsiveness, specialty and network adequacy. Volume may be one consideration but is not the only consideration. Medicaid Health Plans must follow DIFS regulations when contracting with providers.
C27	Contracts and Agreements	Do we have to have all new CCAs signed if we already have one?	No, it is acceptable for Medicaid Health Plans/MIHPs to continue with existing CCAs. The requirement of a new CCA is at the discretion of the MIHP agency and Medicaid Health Plan.

#	Category	Question	Answer
C28	Contracts and Agreements	Do we need to use the specific coordination agreement provided by MDHHS or can Medicaid Health Plans use their own?	If Medicaid Health Plans develop their own CCA, the document must include the MDHHS language.
C29	Contracts and Agreements	Some Medicaid Health Plans want new contracts signed, some are ok using existing contracts - are we required to sign new contracts if we already have an existing contracts?	It is at the discretion to the Medicaid Health Plans as to whether they want MIHP providers to sign a new contract or use existing contracts.
C30	Contracts and Agreements	In the CCA, under Medical Coordination, it states that MIHPs will provide list of enrollees to Medicaid Health Plans (as we currently do). But it also states we have to provide risk screens, plans of care, and discharge summaries upon request. I want to reiterate the importance of not creating additional non-billable work for MIHPs, and recommend that Medicaid Health Plans request this on a random, periodic basis for QI, rather than requiring it for every enrollee.	The Medicaid Health Plan may, as a payer, request information and documentation be shared. It is not anticipated that the Medicaid Health Plans will request the plan of care for every member. Many plans have expressed that they intend to request such information for high acuity beneficiaries only or for a small number of beneficiaries for quality review purposes.

#	Category	Question	Answer
COM1	Communication With Plans and Providers	I am concerned that July 12 is too far out (submitted 05-20) to be able to hold additional meetings. Would it be possible to have more detailed discussions sooner or have a transition period built into the policy so that we will be able to be in compliance?	MDHHS is sensitive to the concerns related to the timing of the transition and will continue to work with Medicaid Health Plans and MIHP providers to reduce disruption of services. It is important that MIHP providers and Medicaid Health Plans work together to establish contractual relationships. The delay of implementation to January 1, 2017 will allow additional time for negotiating multiple contracts. Medicaid Health Plans notify MDHHS when they are ready to begin the contracting and credentialing process. An indicator will be added to the Medicaid Health Plan Contact List and this list will be reissued on a regular basis.
COM2	Communication With Plans and Providers	What type of activities are the Medicaid Health Plans undertaking to prepare for the changes and when will this be communicated to the MIHPs?	Ongoing communication has occurred between MDHHS, MIHP providers, and the Medicaid Health Plans. A meeting was facilitated between the plans and MIHP agencies in July and August, 2016. Subsequent discussions have occurred during regularly scheduled MCH workgroup meetings. The Medicaid Health Plans have been notifying MDHHS when they are ready to begin the contracting and credentialing process. That indicator has been added to the Medicaid Health Plan Contact List and this list will be reissued on a regular basis.
COM3	Communication With Plans and Providers	When an MIHP is having problems with a Medicaid Health Plan, how and who at the state will help?	See BA13.
COM4	Communication With Plans and Providers	What is the rationale for this change?	The transition of administration of MIHP benefits to the Medicaid Health Plans for Medicaid Health Plan enrollees increases the ability for care coordination and aligns with the model of the medical home. The goal is to improve maternal and infant health outcomes.

#	Category	Question	Answer
COM5	Communication With Plans and Providers	Will MIHP providers have access to information about how much money the Medicaid Health Plans are given by the State for MIHP services? This would help us to more effectively negotiate for adequate reimbursement.	Medicaid Health plan capitation rates are based on utilization history and FFS Medicaid rates. Total expenses for MIHP services will be included in the health plan capitation rates.
COM6	Communication With Plans and Providers	Will there be decision makers from the health plans at the meeting in July? We need to have access at the state or at the Medicaid Health Plans to someone who can provide us with solid/reliable answers to all of our questions.	Yes. MDHHS has provided a contracting and care coordination contact for each Medicaid Health Plan. This information may be located at www.michigan.gov/mihp under the Policy and Operations tab.
COM7	Communication With Plans and Providers	If many people oppose this change, will it occur regardless?	Yes. Comments and questions received from MIHP providers and Medicaid Health plans are critical to this transition. All comments are being reviewed to facilitate as smooth of a transition as possible.
COM8	Communication With Plans and Providers	We attempted to contact several Medicaid Health Plans and they were not aware of this new transition. Will you provide us with an updated list of the contact at each Medicaid Health Plan so that we may begin the contract process?	The most current Medicaid Health Plan contact list is located at the MIHP website. If you experience difficulties contacting the plan, please contact your MIHP consultant for assistance. Medicaid Health Plans notify MDHHS when they are ready to begin the contracting and credentialing process. That indicator has been added to the Medicaid Health Plan Contact List and this list will be reissued on a regular basis.

#	Category	Question	Answer
COM9	Communication With Plans and Providers	Will there be additional meetings to those being held in July between MIHPs and the Medicaid Health Plans to share concerns, comments, and build relationships?	Yes. Further discussions continue to occur during regularly scheduled MCH workgroup meetings.
COM10	Communication With Plans and Providers	We have heard that there are communication gaps between the MIHPs and providers. Will the plans be implementing different requirements for communication to providers?	Communication to providers is already a requirement of the MIHP program. Medicaid Health Plans and MDHHS will continue to monitor MIHP communication with health care providers.
COM11	Communication With Plans and Providers	With the time necessary to establish contracts (and no template being provided), it is an unrealistic expectation that this transition will occur by January 1, 2017.	MDHHS is sensitive to the concerns related to the timing of the transition and will work with Medicaid Health Plans and MIHP providers to reduce disruption of services. It is important that MIHP providers and Medicaid Health Plans continue to work together to establish contractual relationships. The delay of implementation to January 1, 2017 will allow additional time for negotiating multiple contracts.
COM12	Communication With Plans and Providers	Has MDHHS predicted how many MIHPs will close due to this transition and could this information be communicated to the public?	MDHHS is unable to predict if any MIHP providers will close due to this transition.
COM13	Communication With Plans and Providers	Can MIHPs and Medicaid Health Plans meet collectively via WebEx or in person not less than quarterly as a group?	Continued discussions are taking place during regularly scheduled MCH workgroup meetings.

#	Category	Question	Answer
COM14	Communication With Plans and Providers	Can fax numbers be added to the Medicaid Health Plan contact list? Is this also the person we should be sharing the MIHP collaboration reports with?	Fax numbers have been added to the "Medicaid Health Plan Points of Contact for MIHP Providers" document on the MIHP website. MIHP collaboration reports should be shared with the care coordination liaison on this document.
COM15	Communication With Plans and Providers	Will MIHP providers provide a list of MIHP programs and which Medicaid Health Plan they contract with so referral can take place quicker than referring client back to the Medicaid Health Plan?	MIHP providers should utilize Medicaid Health Plan provider directories for referral information. The provider directories are listed on each Medicaid Health Plan website.
D1	Data	Is there a way (such as through SSO) that the Medicaid Health Plans could access the Risk Assessments, plan of care or other required MIHP documentation?	Utilization of various features within Care Connect 360 may allow for such exchange of information. MDHHS will continue to explore system options for electronic access to information.
D2	Data	What type of support will the state give to MIHPs in regards to the data requirements set by the health plans?	In an effort to reduce duplication of data collection and reduce the workload for MIHP providers, the state is communicating with the Medicaid Health Plans in regards to current data collection processes and for the potential collaboration for future collection of data.
D3	Data	How will the state ensure accurate information/data is collected from the health plans and who will the plans be accountable to for data integrity?	Both the MIHP providers and the Medicaid Health Plans are accountable to MDHHS for the data that they submit.

#	Category	Question	Answer
D4	Data	How can MIHP agencies provide evidenced-based data if each Medicaid Health Plan is allowed to create their own contracts and data requirements? Not only is this going to be administratively burdensome for the MIHPs, it will allow for a variation in data collection and processing.	Data requirements for MIHP providers is not anticipated to change. MDHHS is communicating with the Medicaid Health Plans to align the data collection process as closely as possible to reduce the administrative burden on both the plans and the MIHP providers.
D5	Data	Does MDHHS provide any assessment of the effectiveness of the MIHP services? Are these reports available to the Medicaid Health Plans? Is this at the program level or at the MIHP provider level?	Yes. Published quasi-experimental studies related to the effectiveness of MIHP services may be accessed on the MIHP website at www.michigan.gov/mihp. These reports are at a statewide program level, not at the MIHP provider level. However, having MDHHS certification indicates the provider is adhering to the fidelity of the MIHP program.
EL1	Eligibility	What is the definition of MIHP eligibility?	**Maternal** – Pregnant Medicaid beneficiaries qualify for MIHP services at any time during the pregnancy. After delivery, a new maternal MIHP case cannot be opened. For purposes of closing a case, services may be provided for up to 60 days after the pregnancy ends or the end of the month in which the 60th day falls. **Infant** – Eligibility for infant MIHP services begins after the infant's birth and hospital discharge. Services are exclusively for the benefit of the infant on Medicaid, primarily by working with the infant's family.

#	Category	Question	Answer
EL2	Eligibility	Is an MIHP provider able to provider services/visits to a mother who has experienced a miscarriage?	Yes, an MIHP provider may continue to provide MIHP services to a Medicaid eligible woman for up to 60 days after the miscarriage. To enroll in MIHP the Medicaid beneficiary must be pregnant. MIHP services may not be initiated for a non-pregnant woman who has experienced a miscarriage.
EL3	Eligibility	What happens if a pregnant woman has a spenddown (deductible)?	It is critical for a pregnant woman to communicate with her case worker about her pregnancy status. The spenddown deductible for a pregnant woman is usually met at the first obstetrician (OB) office visit because the woman incurs the full cost of obstetric services at their first OB visit. The total cost of the OB services must be equal to or greater than the amount of the deductible in order to open Medicaid. She is Medicaid eligible for the remainder of the pregnancy and up to 60 days postpartum.
EN1	Enrollment	Proposed Policy 1611-MIHP states that Medicaid Health Plans are not required to assign MIHP eligible women and infant enrollees to an MIHP provider if the enrollee is currently participating in another pregnancy-related or infant support evidence-based home visiting program. Dual enrollment in MIHP/other HV models (such as Healthy Families America and Early Head Start) is important to ensure the family's needs are being met.	MDHHS agrees that it is critical for families to be able to participate in more than one evidence-based home visiting program when the programs serve different purposes. To avoid duplication of services, Medicaid Health Plans are not required to refer enrollees to MIHP if the enrollee is already participating in an evidence-based home visiting program that provides *pregnancy-related* or *infant support* services. It is the expectation that enrollees would continue to be referred to home visiting services that compliment MIHP services, such as Early On.

#	Category	Question	Answer
EN2	Enrollment	How will Medicaid Health Plans assign clients to MIHP providers? Will they be required to refer beneficiaries to the program that can best meet the beneficiary's needs for language, culture, or disability?	Medicaid Health Plans will refer, not assign, to the MIHP provider that best meets the needs of the enrollee when possible. This is a key component of the Medicaid Health Plan care management approach. Assessing for individual care needs and preferences is part of the Medicaid Health Plan approach to population health management. Plans will, to the best of their ability, honor a woman's choice in MIHP provider. MIHP providers are encouraged to communicate with the Medicaid Health Plans about any specialty services they are able to provide (e.g., culturally or linguistically appropriate providers) and assure the directory accurately reflects specialty services. Health Plans have been given the MIHP provider directory which includes information related to specialty providers.
EN3	Enrollment	Will the plans be required to distribute the referrals equitably to the MIHP providers with whom they have contracts? What type of referral tracking mechanisms will the Medicaid Health Plans have in place?	Care management, member choice, and MIHP performance will be taken into account when distributing referrals. Plans will also maintain existing MIHP provider and beneficiary relationships to the extent possible. Relationships established during previous pregnancies with providers not in the health plan network are not required to be covered. Any questions related to providing out-of-network services will need to be discussed directly with the individual Medicaid Health Plan prior to providing services.
EN4	Enrollment	Is there a specific format that MDHHS currently utilizes to report members who "opt out" of MIHP services?	MIHP providers are encouraged to discuss MIHP enrollment status of Medicaid Health Plan enrollees with the respective Medicaid Health Plan. Communication forms and processes are in development. Any changes to reporting requirements will be communicated in advance.

#	Category	Question	Answer
EN5	Enrollment	It is our understanding that money will be provided to the plan for MIHP services through capitation payment. What checks and balances will be in place to assure that the plans are referring to MIHP and not to other home visiting programs (or none at all)?	Current requirements are that Medicaid Health Plans refer all beneficiaries to MIHP services unless a beneficiary chooses or is enrolled in an equivalent evidence-based home visiting program. MDHHS will monitor utilization of MIHP services and health plan protocols will be reviewed through the annual MDHHS contract compliance review process.
EN6	Enrollment	What happens if we have already begun to provide services before the infant is assigned to a plan? There are occasions when the infant has a different Medicaid Health Plan because the infant's PCP does not accept the mother's Medicaid Health Plan.	If a woman is in a Medicaid Health Plan at the time of the birth of her baby, the baby will be enrolled in that plan for at least birth month. The family could prospectively choose a different health plan for the infant. Medicaid Health Plans must support the enrollee in their choice of MIHP provider and to support current service relationships between MIHP provider and enrollee, including extending services to the infant with the same provider who rendered maternal services. Relationships established during previous pregnancies with providers not in the health plan network are not required to be covered. Any questions related to providing out-of-network services will need to be discussed directly with the individual Medicaid Health Plan prior to providing services.
EN7	Enrollment	Will a woman be able to sign up with an MIHP agency before she has chosen or been assigned to a Medicaid Health Plan? If so, who does the MIHP bill? Similarly, if, at the time of assessment, a client has FFS and it is expected she will enroll in a Medicaid Health Plan, should the MIHP hold off billing until the plan is chosen?	Yes, a woman can sign up with an MIHP provider while she is still FFS. Services provided during the FFS period should be billed FFS. Medicaid Health Plans must support the enrollee in their choice of MIHP provider and to support current service relationships between the MIHP provider and enrollee. Relationships established during previous pregnancies with providers not in the health plan network are not required to be covered. Any questions related to providing out-of-network services will need to be discussed

#	Category	Question	Answer
			directly with the individual Medicaid Health Plan prior to providing services.
EN8	Enrollment	If an MIHP gets a referral from WIC on the same day another MIHP receives a referral for the same client from a provider, plan, or self-referral, who should service the client?	Communication between clients, MIHP providers, plans, hospitals, and providers is critical. Operationally, this will not change. Only one Maternal (per pregnancy) or Infant Risk Identifier is covered for each MIHP beneficiary. The first claim received from a contracted provider will be the first claim eligible for payment. MIHP providers should continue checking the MIHP database to ensure another Risk Identifier has not already been completed.
EN9	Enrollment	Will we be required to send a monthly roster to the plans of enrolled infants like we are currently required to do for maternal cases?	Having this process in place for infants would be helpful. Communication forms and processes are in development. Any changes to reporting requirements will be communicated in advance.
EN10	Enrollment	Will MIHP referrals continue to be allowed from providers, WIC, self-referral, other MIHPs (transfer of care), and the Medicaid Health Plans?	Yes, referrals can continue to come from all of these sources. The referring entity is encouraged to incorporate checking health plan enrollment as part of their process and identify in-network MIHP providers.
EN11	Enrollment	How will MDHHS ensure equity for all MIHPs?	The Medicaid Health Plans may choose which MIHP providers they contract with. MDHHS will maintain their MIHP certification process to ensure providers are adhering to Medicaid policy and operational requirements.

#	Category	Question	Answer
EN12	Enrollment	A mother who resides in the Upper Peninsula delivers a newborn who requires specialized care in a down state hospital. Is there a possibility that the infant will be enrolled in a different health plan than the Upper Peninsula Health Plan (UPHP)?	Yes, this is a possibility. MDHHS is aware of this issue and is working to minimize this occurrence. These are handled today on a case-by-case basis.
EN13	Enrollment	Occasionally infants are born and Medicaid is applied for in another county from that which the infant resides and the Medicaid Health Plan is assigned accordingly. This can be an issue when the child is discharged to their residence and the Medicaid Health Plan does not service the county of residence. How will this be operationalized?	Medicaid Health Plan enrollment is based upon the county of residence. There are internal processes in place to correct enrollment discrepancies.
EN14	Enrollment	Will this transition allow the state to stop adding MIHP programs in areas where the market is already saturated with MIHPs?	The Medicaid Health Plans may choose which MIHP providers they contract with. There will be no change to the MDHHS MIHP certification process.
EN15	Enrollment	Would enrollee assignment reduce innovation in the field of outreach activities?	The department does not anticipate any changes to outreach activities.

#	Category	Question	Answer
EN16	Enrollment	Will the Medicaid Health Plans have access to the MIHP database to check for MIHP enrollment or are we to rely on self-report? How can participation in another evidence-based home visiting program be identified?	Medicaid Health Plans must rely on beneficiary self-reporting to identify if a woman is enrolled in MIHP or an equivalent evidence-based home visiting program. MDHHS will identify equivalent evidence-based home visiting programs and make this information available to Medicaid Health Plans and MIHP providers.
EN17	Enrollment	Our health system has a process for automatic MIHP referrals. How will this potentially conflict with the proposed referral requirements of the Medicaid Health Plans?	Because the Medicaid Health Plans will have their own network of MIHP providers, the health system may need to add an additional step of verifying beneficiary health plan enrollment as part of the referral process.
EN18	Enrollment	We request that policy language be revised to state, "Medicaid Health Plans are required to refer all MIHP eligible women and infant enrollees to an MIHP provider **within one month of plan notification of the enrollee's MIHP eligibility**. If the member chooses not to enroll in MIHP services, the plan has met its contractual obligation once the initial referral to the MIHP is made."	Consideration has been given to address this comment and language has been adjusted in the final bulletin, MSA 16-33.

#	Category	Question	Answer
EN19	Enrollment	What is the "typical" caseload of a MIHP provider?	There is not a typical caseload. Variables that may impact the caseload are: MIHP specialization, staffing capacity, and fluctuations in reported births and pregnancies.
EN20	Enrollment	Will Medicaid Health Plans pay for more than one evidenced-based program?	No. Medicaid Health plans may provide additional Medicaid non-covered services at their discretion.
EN21	Enrollment	I am worried that if an MIHP provider receives a referral for a beneficiary with a non-contracted Medicaid Health Plan and the next step is to refer back to the Medicaid Health Plan for a referral to a contracted MIHP provider the enrollment will not happen, not because the Medicaid Health Plan won't do their job but because any barrier to enrollment often results in no services being provided. Will MDHHS have a way to monitor this?	Please refer the beneficiary to the Medicaid Health Plan for a referral to a contracted MIHP provider.
EN22	Enrollment	If a mom loses coverage during pregnancy, but it is then reinstated, will the coverage be retroactive and if so, for how long?	If the enrollee's coverage is reinstated within 60 days, she will be automatically enrolled in her previous health plan prospectively (meaning effective the next available month). Any services provided during the retroactive eligibility period would be covered under FFS. If the coverage is reinstated after 60 days, she will be sent an enrollment packet and will be asked to choose a health plan.

#	Category	Question	Answer
EN23	Enrollment	My question is with regard to providing mileage reimbursement for infants who have FFS and then switch to a Health Plan the next month. Is the MIHP able to provide mileage reimbursement for the infant's medical, WIC, etc., appointments while they are FFS even though the Medicaid Health Plan coverage would be retroactive?	Infant services must be billed using the infant's Medicaid ID#. Newborns will be enrolled into the same plan as the mother was enrolled on the date of delivery, at least for the newborn's month of birth. Regardless which option the MIHP provider chooses, the Infant Risk Identifier must be entered into the MIHP database upon completion. Billing options are outlined below: 1. MIHP providers may bill FFS but must understand that any FFS payment will be recouped upon newborn Medicaid Health Plan enrollment and the MIHP provider will then need to bill the appropriate Medicaid Health Plan. 2. MIHP providers may hold claims submission to the Medicaid Health Plan until the newborn enrollment shows in CHAMPS. The enrollment process normally takes less than 30 days. 3. If the MIHP provider knows which plan the mother was enrolled with on the date of delivery, and the newborn has a Medicaid ID#, the MIHP provider may contact the Medicaid Health Plan and ask that a Service Request be submitted to MDHHS to have the enrollment processed. MIHP providers should wait until the enrollment shows in CHAMPS before submitting claims. If Mom is FFS at time of delivery, baby will always be FFS until a health plan enrollment choice is made (normally within 60 days). For maternal cases there is no retroactive health plan enrollment so the MIHP should bill based on the eligibility in CHAMPS at the time services are rendered.

#	Category	Question	Answer
FC1	Freedom of Choice	Will Medicaid Health Plans offer more than one choice of MIHP provider to their enrollees?	MDHHS anticipates that Medicaid Health Plans will offer choice of MIHP providers when more than one is available.
FC2	Freedom of Choice	Is consideration being given to requiring the Medicaid Health Plans to offer MIHP services that meet cultural needs such as Tribal services?	Yes. MDHHS recognizes the importance of providing such specialized services to Medicaid Health Plan enrollees and will encourage the plans to establish relationships with these specialized providers. Medicaid Health Plans will refer to the MIHP provider that best meets the needs of the enrollee when possible. Assessing for individual care needs and preferences is a key component of the population health management approach. To the best of their ability, Medicaid Health Plans will honor a woman's choice of MIHP provider. Medicaid Health Plans have been given the MIHP provider directory which includes information related to specialty providers. MIHP providers are encouraged to communicate with the Medicaid Health Plans about any specialty services they are able to provide (e.g., cultural, linguistically appropriate providers, or those providing services for the visually or hearing impaired).
FC3	Freedom of Choice	Will there be an allowance for beneficiaries to enroll with an MIHP that is not contracted with that beneficiary's Medicaid Health Plan?	Questions related to providing out-of-network services will need to be discussed directly with the individual Medicaid Health Plan *prior* to providing services. If a beneficiary is already enrolled in a Medicaid Health Plan the beneficiary should be utilizing a contracted MIHP provider. Plans will also, to the best of their ability, honor a woman's choice in MIHP provider. Medicaid Health Plans have been informed how to access the MIHP Provider Directory, which includes information related to specialty providers. MIHP providers are encouraged to communicate with the Medicaid Health Plans about any specialty services they are able to provide (e.g., specialized cultural or linguistic services, or services for those with hearing or visual impairments).

Maternal Infant Health Program (MIHP) Benefits Administered by the Medicaid Health Plans
Frequently Asked Questions

#	Category	Question	Answer
FC4	Freedom of Choice	All eligible pregnant women and infants should be referred to the most appropriate provider of evidence-based maternal and infant support services to meet their respective needs and the reimbursement should be consistent for all qualified providers and not restricted to a single program.	If the beneficiary chooses an evidence-based maternal and infant support service other than MIHP, that choice will be honored. However, Medicaid and the Medicaid Health Plans are only required to reimburse for MIHP.
FC5	Freedom of Choice	Does proposed policy 1611-MIHP restrict the Medicaid Health Plans from using state capitation payments to support the provision of non-MIHP evidence-based maternal and infant support services such as Nurse Family Partnership?	No. Medicaid Health plans may provide additional Medicaid non-covered services at their discretion.

#	Category	Question	Answer
FC6	Freedom of Choice	Medicaid Health Plans have authorization requirements in place for services to be provided by a non-contracted providers. Medicaid Health Plans often have authorization requirements for services provided by a non-contracted provider. When non-contracted MIHP providers are providing services to Medicaid Health Plan members, please confirm if plans can require authorization or notice requirement for assessments and visits, so claims will be able to go through system without hitting prior authorization edit.	MIHP providers must check eligibility and health plan enrollment at every visit. Once the client is enrolled in a Medicaid Health Plan, the MIHP provider must communicate with the Medicaid Health Plan *prior* to providing services. The Medicaid Health Plan may require documentation to support a current relationship.
FC7	Freedom of Choice	For specific populations, will the Medicaid Health Plans be required to have appropriate MIHP providers either in-network or a process in place to allow out-of-network access? Example: A Native American woman is in a Medicaid Health Plan and becomes pregnant. Is the Medicaid Health Plan required to refer her to the most culturally appropriate provider (i.e., an MIHP run by a tribe or tribal health center OR Family Spirit)?	MDHHS recognizes the importance of providing such specialized services to Medicaid Health Plan enrolled beneficiaries and will encourage the plans to establish relationships with these specialized providers. Plans will also, to the best of their ability, honor a woman's choice in MIHP provider. Health Plans have been given the MIHP provider directory which includes information related to specialty providers. MIHP providers are encouraged to communicate with the Medicaid Health Plans about any specialty services they are able to provide (e.g., specialized cultural or linguistic services, or services for those with hearing or visual impairments).

#	Category	Question	Answer
FC8	Freedom of Choice	Can you list Medicaid Health Plans that each MIHP contracts with on the MIHP Coordinator Directory?	MDHHS will consider providing a list of Medicaid Health Plans and MIHP contracted providers.
MARK1	Marketing and Outreach	Will the MIHP Operations Guide still be relevant to incentives? If there is variation between what is allowed by the health plans and what is allowed for FFS programs, would fidelity to the model be impacted?	The MIHP Operations Guide will continue to be a relevant companion to the Medicaid Provider Manual. Any variations that may exist related to incentives allowed in the Medicaid Health Plans and the FFS program should not impact the fidelity of the MIHP program. Remember that incentives may not be used to encourage a beneficiary to engage with a particular MIHP provider. Incentives may continue to be used by MIHP providers when milestones are met for already engaged beneficiaries.
MARK2	Marketing and Outreach	Can MIHPs market to a higher number of participants in their agency or only have clients through the Medicaid Health Plan?	Yes, outreach may be performed as there will still be beneficiaries that will never be enrolled into a Medicaid Health Plan due to reasons for managed care enrollment exclusion (i.e., other PPO or HMO commercial insurance). If the MIHP provider identifies a beneficiary that is enrolled in a Medicaid Health Plan that the MIHP provider is not contracted with, the MIHP provider should refer the beneficiary to the Medicaid Health Plan for a referral to a contracted MIHP provider.
PRB1	Payment, Rates and Billing	Local Health Departments (LHDs) utilize Medicaid Cost Based Reimbursement processes. Will LHDs continue to be eligible to utilize such processes?	Yes, there is no anticipated change in the Medicaid Cost-Based Reimbursement process for LHDs.

#	Category	Question	Answer
PRB2	Payment, Rates and Billing	It is unrealistic to expect the health departments to bill commercial insurances for a Medicaid program service. Like many health departments, we currently do not bill commercial insurances.	MIHP providers are expected to maintain contractual agreements with Medicaid Health Plans in their service area to receive payment for claims for services provided to Medicaid Health Plan enrollees. Because MIHP services are a Medicaid only benefit, MIHP providers are not subject to COB and TPL rules. MIHP providers do not need to bill a commercial insurer and receive a denial prior to billing the Medicaid Health Plan for services.
PRB3	Payment, Rates and Billing	Is it possible for MIHP services to have a unique CPT code so the Medicaid Health Plans are able to set their adjudication edits to pay claims regardless of other insurance?	At this time MDHHS is not anticipating changes to the coding and reimbursement process. Because MIHP services are a Medicaid only benefit, MIHP providers are not subject to COB and TPL rules. MIHP providers do not need to bill a commercial insurer and receive a denial prior to billing the Medicaid Health Plan. All Medicaid Health Plans have confirmed that the commercial denial is unnecessary for MIHP services.
PRB4	Payment, Rates and Billing	Will rates for MIHP services differ from those currently paid by FFS? How will the rates be determined and will they differ from plan to plan? I am concerned that the plans will carve out services to offset administrative expenses.	Rates are a contractual negotiation between the MIHP provider and the Medicaid Health Plan. Medicaid Health Plans will be required to maintain the current MIHP service model.
PRB5	Payment, Rates and Billing	Will CHAMPS still be used in processing claims or will there be an individual process for each Medicaid Health Plan?	Claims for FFS beneficiaries will continue to be submitted via CHAMPS. Claims for Medicaid Health Plan enrolled beneficiaries will be submitted to the beneficiary's Medicaid Health Plan.

#	Category	Question	Answer
PRB6	Payment, Rates and Billing	There is absence of language around reimbursement rates in the proposed policy 1611-MIHP. Is there a way for the policy to set a standard for minimum reimbursement, or a reimbursement range for the plans to adhere to?	It is not the intent of the policy, bulletin MSA 16-33, to define reimbursement rates for MIHP services. Rates will be negotiated as part of the contractual process between the Medicaid Health Plans and the MIHP providers. Rates for FFS beneficiaries are not impacted by this transition. If services are Medicaid Health Plan approved and provided by an out of network MIHP provider, those services will be reimbursed at the FFS rate.
PRB7	Payment, Rates and Billing	If we complete a Risk Identifier and the client declines MIHP services, or we are unable to complete additional visits, will the Medicaid Health Plan provide payment to the MIHP for that completed Risk Identifier?	Yes, the Medicaid Health Plan will be required to pay claims for such services when the services were provided in alignment with current Medicaid policy.
PRB8	Payment, Rates and Billing	How will agencies be paid by the Medicaid Health Plans (per visit vs. lump sum)?	Payment will be determined through the contractual agreement established between the MIHP provider and the Medicaid Health Plan and could be per visit or lump sum. If services are Medicaid Health Plan approved and provided by an out-of-network MIHP provider, those services will be reimbursed at the FFS rate.
PRB9	Payment, Rates and Billing	Will payment for services be based upon "risks"?	Payment will be determined through the contractual agreement established between the MIHP and the Medicaid Health Plan. If services are Medicaid Health Plan approved and provided by an out-of-network MIHP provider, those services will be reimbursed at the FFS rate.

#	Category	Question	Answer
PRB10	Payment, Rates and Billing	We currently bill CPT 99402 for services provided by a RN. Will this procedure code change?	No. CPT 99402 will remain the appropriate code to include on claims for maternal and infant professional visits. With the exception of the transportation codes, MIHP services will continue to utilize the CPT/Healthcare Common Procedure Coding System (HCPCS) codes located within the MIHP database.
PRB11	Payment, Rates and Billing	Did I understand correctly that services provided to FFS beneficiaries will still be billed through CHAMPS? Will we still be able to submit claims electronically or is there going to be a paper billing method? What is the billing system used by the plans?	Claims for FFS beneficiaries will continue to be submitted via CHAMPS. Claims for Medicaid Health Plan enrolled beneficiaries will be submitted to the beneficiary's Medicaid Health Plan. All Medicaid Health Plans support electronic billing.
PRB12	Payment, Rates and Billing	Currently if we use an accurate "public health diagnosis code" Medicaid is set up to bypass the need to bill commercial insurance. Will this process change with the plans?	Appropriate diagnosis codes are required on all claims submitted to both Medicaid and the Medicaid Health Plans. Because MIHP services are a Medicaid only benefit, MIHP providers are not subject to COB and TPL rules. MIHP providers do not need to bill a commercial insurer and receive a denial in order to bill the Medicaid Health Plan for services.
PRB13	Payment, Rates and Billing	MIHPs currently are experiencing problems receiving payment for Medicare/Medicaid beneficiaries (MI Health Link participants). How will this transition impact this population?	This transition will not impact this population. They are separate benefit programs.
PRB14	Payment, Rates and Billing	Who will pay for MIHP services while the beneficiary has straight Medicaid?	Claims for FFS beneficiaries should be submitted through CHAMPS. There are no changes to the claims submission process for FFS beneficiaries.

#	Category	Question	Answer
PRB15	Payment, Rates and Billing	The Medicaid Provider Manual states that if the Risk Identifier does not show a member qualifies for MIHP services, but professional observation suggests they would benefit, is the member still able to get MIHP services? Please confirm how determination of coverage is made. What criteria is used to determine coverage other than the Risk Identifier?	On the rare occasion when the Risk Identifier does not indicate the need for MIHP services but professional observation suggests the beneficiary would benefit from MIHP services, the MIHP provider must obtain authorization from the Medicaid Health Plan to proceed with MIHP services. Documentation must support how the beneficiary may benefit from MIHP services.
PRB16	Payment, Rates and Billing	The Medicaid Provider Manual discusses blended visit – for MIHP services provided to multiple infants or infant and mom during the same period. How is this billed? Which Medicaid ID does the MIHP provider use? The fee schedule does not address reimbursement for blended visits. What is the reimbursement for services that are rendered during blended visits?	A maternal/infant blended visit is billed using either the infant's or mother's Medicaid ID#. For blended visits conducted with multiples, the MIHP provider determines the infant with the most identified "risks" and bills the blended visit using that infant's Medicaid ID#. Blended visits are considered a professional visit and are reimbursed at the rate identified for a professional visit.

#	Category	Question	Answer
PRB17	Payment, Rates and Billing	For infant MIHP services, does the MIHP have to bill using infant Medicaid ID? If there is a delay in enrollment of the newborn into Medicaid Health Plan, how will that impact MIHP reimbursement for infant services? Will MIHPs hold the claim until the newborn enrollment is processed? This scenario could potentially apply to maternal cases as well in which the beneficiary has not yet enrolled in a Medicaid Health Plan. Will there be consideration for retroactive billing once the beneficiary is assigned to a plan?	See EN23
PRB18	Payment, Rates and Billing	The Maternal Infant Health Program chapter of the Medicaid Provider Manual Section 2.8 – allows the first 18 visits billing regular code, second 18 billing drug exposed code – what code is used to identify these? Is this a diagnosis code? Is this on the fee schedule?	The code utilized by MIHP providers for a professional visit provided to the drug-exposed infant is CPT 96154 and may be located on the MIHP fee schedule. Visits beyond the initial nine professional visits require documentation by the medical care provider, such as a physician's order, to support the need for the additional visits. Documentation must be maintained in the MIHP record.

#	Category	Question	Answer
PRB19	Payment, Rates and Billing	What service is code 96154 (Interv Health/Behav Fam w/Pt)? If it is a behavioral health visit, does it count towards the 20 mental health outpatient visits? If not, is this part of the 9 MIHP visits? Or is this in addition to the 9 visits? The Medicaid fee schedule directs provider to bill 2 units to receive full reimbursement. Will this apply to Medicaid Health Plans? Will MIHPs be billing 2 units on the same date of service for this procedure code?	CPT 96154 is the procedure code used by the MIHP for professional visits conducted with the drug-exposed infant, and does not count as a mental health outpatient visit. Because CPT 96154 describes a 15 minute increment of service and the MIHP visit is required to be at a minimum 30 minutes in length, it is appropriate to bill two units of CPT 96154 for a single encounter on a single date of service.
PRB20	Payment, Rates and Billing	Will the Medicaid Health Plans allow for out-of-network billing?	Medicaid Health Plans must support the enrollee in their choice of MIHP provider and support a pre-existing MIHP service relationship between MIHP provider and enrollee for that pregnancy. If that current relationship is with an out-of-network MIHP provider or the beneficiary requires specialty services not available in-network, the Medicaid Health Plan will be required to allow out-of-network billing. The MIHP provider must notify the Medicaid Health Plan of the current relationship and obtain approval for the continuation of services.
PRB21	Payment, Rates and Billing	What will be the schedule for payments to the MIHPs from the Medicaid Health Plans - monthly or weekly?	Payment arrangements should be discussed during the MIHP/Medicaid Health Plan contracting process. Typically Medicaid Health Plans pay weekly or bi-weekly.

#	Category	Question	Answer
PRB22	Payment, Rates and Billing	If we have a Medicaid number for the infant and a Risk Identifier is done in birth month but the infant eligibility states FFS can we bill the mother's Medicaid Health Plan?	See EN23.
PRB23	Payment, Rates and Billing	Previously, one MIHP agency provided Child Birth Education (CBE) and parenting education to beneficiaries from multiple MIHPs. The CBE instructing MIHP only billed for the class. The other MIHP completed all other MIHP services. Will this still be allowed?	Policy does not prohibit this practice. Coordination of maternal and infant services is encouraged when more than one MIHP provider is involved in the family's care.
PRB24	Payment, Rates and Billing	Is there a list of ICD-10 codes that we can bill?	Providers are required to use appropriate diagnosis codes on all claims submitted to both Medicaid and the Medicaid Health Plans. A list will not be provided.
PRB25	Payment, Rates and Billing	Can an MIHP provider bill an individual who has not met their spenddown/deductible for MIHP services?	MIHP is a Medicaid only benefit. MIHP providers should be checking eligibility before rendering services to ensure the individual has Medicaid eligibility on the date of service. It is critical for a pregnant woman to communicate with her case worker about her pregnancy status. The deductible for a pregnant woman is usually met at the first OB office visit because the woman incurs the full cost of obstetric services at their first OB visit. The total cost of the OB services must be equal to or greater than the amount of the deductible in order to open Medicaid. She is Medicaid eligible for the remainder of the pregnancy and up to 60 days postpartum.

#	Category	Question	Answer
PRB26	Payment, Rates and Billing	The Medicaid Provider Manual says the Risk Identifier is performed and then entered into the MIHP database. Is the Risk Identifier billed in addition to the initial assessment? What code is used to bill this service? H1000? Is the comp multi-disciplinary evaluation – the initial assessment? Does the MIHP provider bill the Risk Identifier and evaluation separately on two different dates – can they be performed and reimbursed on the same date?	The Risk Identifier is a component of the Initial Assessment visit and is not separately reimbursed. Please refer to the MIHP fee schedule for the applicable CPT/HCPCS codes.
PRB27	Payment, Rates and Billing	99402, H1000, H2000, T1023- we assume that these codes should only be payable when billed in the appropriate location, correct?	Claims for these services should be submitted with the appropriate place of service.
PRB28	Payment, Rates and Billing	Can S9442, S9443, S9444 be billed in a home, office, or both?	Yes, these codes could be billed in either place of service. Claims for these services should be submitted with the appropriate place of service.
PRB29	Payment, Rates and Billing	What rendering and servicing provider will be used on the MIHP claim?	Claims for MIHP services utilize the NPI of the agency as the billing provider. It is not required that a rendering provider be included on the claim for MIHP services.
PRB30	Payment, Rates and Billing	Should the plans expect any change in current MIHP billing for services?	With the exception of the transportation codes, MIHP services will continue to utilize the CPT/HCPCS codes located within the MIHP database.

#	Category	Question	Answer
PRB31	Payment, Rates and Billing	Will health departments with MIHPs use a different NPI number for MIHP services than the NPI the health departments use for other services such as immunizations or chlamydia screening etc. if they provide those services for example?	Health departments may provide MIHP services using a different NPI from that associated with other clinic services (e.g., family planning services) or utilize one NPI for all services, including MIHP services.
PRB32	Payment, Rates and Billing	I am concerned about the transition in relation to billing. I am a small business and now receive my payments very timely. I am concerned the transition will not be smooth and there will be problems.	MIHP providers and Medicaid Health Plans should be in discussion now to work out the billing processes so that it is clearly outlined by January 1, 2017. Some plans are conducting WebEx trainings about billing. Medicaid Health Plans were reminded to coordinate with other plans so that these trainings are at different times. Medicaid Health Plans have been communicating with MDHHS regarding upcoming trainings.
PRB33	Payment, Rates and Billing	Will Medicaid Health Plan billing web trainings be archived? Can we post links on the MIHP websites?	MDHHS will discuss this with the Medicaid Health Plans and share information as it becomes available.
PRB34	Payment, Rates and Billing	Will there be any pre claim/payment review or testing to make sure MIHP providers are able to bill correctly?	Some plans are planning to test. MDHHS will collect this information and share it with MIHP providers.

#	Category	Question	Answer
PRB35	Payment, Rates and Billing	I was under the impression that if we enrolled an infant into MIHP when they had straight Medicaid we billed straight Medicaid and received payment from Medicaid. But when the infant goes onto a health plan and the health plan is backdated that we would have to rebill to the health plan. Would that be the same for mileage then since it was just said that we could bill for mileage when infant was on straight Medicaid?	See EN23.
PA1	Prior Authorization	Proposed Policy 1611-MIHP states that Medicaid Health Plans may not require prior authorization for the initial assessment visit. Where is this currently in policy?	Current Medicaid policy does not require prior authorization for MIHP services. Bulletin MSA 16-33 states that Medicaid Health Plans, at a minimum, may not require prior authorization for the initial risk assessment visit. After further consideration and stakeholder input, the proposed policy was revised to indicate that Medicaid Health Plans will not require PA for the initial risk assessment Visit, professional visits (which may total up to 18 visits for the infant) and drug exposed infant visits when provided within the criteria and limits established in Medicaid policy. There will also be no PA for MIHP lactation support visits, childbirth education, or parenting education when provided within the criteria and limits established in Medicaid policy.
PA2	Prior Authorization	How many visits will a prior authorization cover?	See PA1

#	Category	Question	Answer
PA3	Prior Authorization	Will the clients enrolled in MIHP prior to January 1, 2017 need a prior authorization to continue to receive services from the current MIHP provider?	MIHP providers must check eligibility at every visit. Once the beneficiary is enrolled in a Medicaid Health Plan, the MIHP provider must notify the Medicaid Health Plan of the current relationship and obtain approval for the continuation of services. Any questions related to providing out-of-network services will need to be discussed directly with the individual Medicaid Health Plan prior to providing services.
PA4	Prior Authorization	Use of prior authorization by Medicaid Health Plans could violate the MIHP model/evidence-based practice if the number of visits are limited.	After further consideration and stakeholder input, project #1611-MIHP was revised to indicate that Medicaid Health Plans will not require PA for the initial risk assessment visit, professional visits (which may total up to 18 visits for the infant) and drug exposed infant visits when provided within the criteria and limits established in Medicaid policy. There will also be no PA for MIHP lactation support visits, childbirth education, or parenting education when provided within the criteria and limits established in Medicaid policy.
PA5	Prior Authorization	Due to the level of socio-economic issues our population faces each day, the level of urgent and emergent needs are great, to say the least. Often times we are confronted with beneficiaries in crisis situations. The requirement for prior authorization could negatively impact the timeliness of the services we are able to provide.	See PA1
PA6	Prior Authorization	Will the MIHPs need to obtain prior authorization to continue to service clients already enrolled in MIHP once this transition occurs?	See PA3

#	Category	Question	Answer
PA7	Prior Authorization	The Medicaid Health Plans are currently required to waive PA requirements for local health departments. Will this be true for the MIHPs operating out of local health departments?	See PA1
PA8	Prior Authorization	The Medicaid Provider Manual states that MIHP providers may provide assessment and up to 9 visits. Please confirm that Medicaid Health Plans would be allowed to require authorization for a portion of the 9 visits. (For example, require authorization after 5 visits?) Additional visits require authorization or physician order from medical care provider. Once MIHP services become Medicaid Health Plan benefit, please confirm if the Medicaid Health Plan would be responsible for authorization of services for Medicaid Health Plan members? Will authorization/documentation still required from the physician?	There are no policy changes related to the requirement for physician authorization/physician orders to MIHP services. See PA1

#	Category	Question	Answer
PA9	Prior Authorization	The Medicaid Provider Manual states that older kids can get MIHP services from 12-18 months of age if written authorization from a Medical care provider. Will MIHP be required to obtain authorization from the Medicaid Health Plan for these cases to engage these cases? Is medical care provider documentation still needed? What criteria is used to determine coverage for these members? Does the MIHP provider use the Risk Identifier tool in these situations?	Screening tools and educational materials utilized by the MIHP are designed for use with infants. The initial assessment visit for a child older than 12 months of age or a professional visit or other MIHP service beyond 18 months of age is subject to Medicaid Health Plan prior authorization requirements. MIHP providers must contact the Medicaid Health Plan before providing services. Medicaid Health Plans will receive guidance from MDHHS in order to evaluate medical documentation and make a coverage determination. The MIHP provider must maintain the health plan authorization in the MIHP record.
PA10	Prior Authorization	If a mom is in a Medicaid Health Plan and self-refers and visits an out-of-network MIHP, what happens?	The MIHP provider must check eligibility and Medicaid Health Plan enrollment for every visit. If a beneficiary is enrolled in a Medicaid Health Plan that the MIHP provider is not contracted with, the MIHP provider should instruct the beneficiary to contact the Medicaid Health Plan to assist in locating an MIHP within the Medicaid Health Plan's network. The Medicaid Health Plan may deny claims for out-of-network services.

#	Category	Question	Answer
PA11	Prior Authorization	If no prior authorization is required how does the MIHP know how many visits the beneficiary is entitled to at any given time during her pregnancy or for the infant after the Medicaid Health Plan enrollment has been established? What if the client is a transfer from another agency?	MIHP providers should coordinate and communicate with the Medicaid Health Plans regarding the number of visits provided. If the client is a transfer it would be expected that the transferring MIHP provider provide documentation to the new MIHP provider that would show what services have already been provided.
PA12	Prior Authorization	Under the prior authorization of service it states that MIHP service in excess of limits established in Medicaid policy are subject to Medicaid Health Plan prior authorization requirements. Does this mean we could provide more than 9 visits to expecting women if they are approved by the Medicaid Health Plan?	If a beneficiary requires services in excess of limits established by Medicaid policy, the MIHP will need to obtain prior authorization from the Medicaid Health Plan prior to rendering additional services to the individual.
PA13	Prior Authorization	When the transition takes place January 1, 2017, if we have current signed physician orders for additional MIHP visits for infant (i.e., drug exposed or if we just needed more visits for a family) will the Medicaid Health Plan honor those or do we have to go back and get prior authorization for those clients?	Yes, Medicaid Health Plans will honor existing physician orders for MIHP services.

#	Category	Question	Answer
PA14	Prior Authorization	If the Health Plans do approve additional visits in excess of limits established in Medicaid policy, how do we account for this in the Discharge Summary?	Providers should document that additional visits were approved by the Medicaid Health Plan in the Discharge Summary.
QR1	Quality and Reporting	The different reporting requirements that the Medicaid Health Plans may impose will be difficult for the MIHPs to operationalize.	We are aware that there may be reporting requirements by the plans, in addition to those currently required by MDHHS. MDHHS and the Medicaid Health Plans will attempt to align any additional data collection and performance measurement requirements so that these can be operationalized in the most efficient manner possible.
QR2	Quality and Reporting	Will quality outcomes monitored by and collected by MDHHS for MIHP providers be available to the Medicaid Health Plans?	Yes. Published quasi-experimental studies related to the effectiveness of MIHP services may be accessed on the MIHP website at www.michigan.gov/mihp. These reports are at a statewide program level, not at the MIHP provider level. However, having MDHHS certification indicates the provider is adhering to the fidelity of the MIHP program.
QR3	Quality and Reporting	Will MDHHS continue to monitor adherence to the Medicaid Provider Manual (fidelity, proper use of forms), in addition to certifying MIHP providers? What will be the role of the Medicaid Health Plans in monitoring adherence?	Yes, MDHHS will continue to certify MIHP providers and monitor MIHP providers for adherence to Medicaid Policy and MIHP program operations. While Medicaid Health Plans will not have a role in the certification process, MDHHS may consider, at a future time, adding a step to the certification process that verifies coordination is happening appropriately between the Medicaid Health Plans and the MIHP providers.

#	Category	Question	Answer
QR4	Quality and Reporting	How will a Medicaid Health Plan know when an MIHP has been certified or decertified?	A directory of MDHHS certified MIHP providers is located on the MIHP website. All providers listed are eligible to provide services. The Medicaid Health Plans will be notified of changes in the MIHP certification status via email to the MIHP provider and Medicaid Health Plan Liaisons. The MIHP provider directory is updated on a regular basis as changes occur.
TC1	Training and Certification	Will there be changes in the MIHP certification process or in the mandatory training that currently exists through MDHHS? What will be the role of the Medicaid Health Plan related to these processes?	MDHHS will continue to certify MIHP providers and be responsible for the mandatory training for MIHP providers. MIHP providers will continue to be required to adhere to Medicaid program policies and procedures. MDHHS will continue to update training and certification procedures as necessary.
TC2	Training and Certification	Will MIHPs have two "audits" – one by the state and one by the health plans?	The certification and recertification conducted between MIHP providers and MDHHS will remain. The Medicaid Health Plans may require additional review of MIHP operations. To decrease duplication of various aspects of the review processes, MDHHS is communicating the details of the current MDHHS certification/recertification process with the Medicaid Health Plans so that these reviews can be operationalized in the most efficient manner possible. The certification/recertification tool can be accessed on the MIHP website at: www.michigan.gov/mihp.

#	Category	Question	Answer
TC3	Training and Certification	Please confirm that MDHHS will continue to provide Medicaid Health Plans with a list of certified MIHPs operating in each county on a regular basis. Will this be provided monthly? Is a list of certified MIHP providers and status of certification (provisional vs. full accreditation) available on the MDHHS website? If there are changes to the MIHP's certification status, how will Medicaid Health Plans be notified?	A directory of MDHHS certified MIHP providers is located at the MIHP website. All providers listed are eligible to provide services. The Medicaid Health Plans will be notified of changes in the MIHP certification status via email to the MIHP Medicaid Health Plan Liaisons. The MIHP provider directory is updated on a regular basis as changes occur.
TC4	Training and Certification	Does MDHHS review MIHP liability insurance during certification process? Medicaid Health Plans providers are required to maintain certain insurance levels, will MIHPs be able to meet these requirements?	No, MDHHS does not currently review MIHP liability insurance during the certification process. MIHPs will be required to adhere to provider contract requirements with the Medicaid Health Plans, which may include liability insurance requirements.
TC5	Training and Certification	An MIHP provider may have a service area smaller than the contracted Medicaid Health Plan's service region. What are the steps necessary to expand the MIHP service to match the Medicaid Health Plan service area?	The MIHP provider must notify MDHHS of the intent to expand their service area beyond what was approved at the time of certification.